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games are played to select the best adult performers, and these are then groomed to go forward to their ultimate degree of perfection. Those who drop out tend to accept the role of observer. The "game" is played in Britain for the participant's pleasure. Poor performers are encouraged to continue rather than enter the stands to watch. Strength-producing exercise finds this unfair competition, for in it there is little pleasure of participation. Perhaps this accounts for the readiness with which Dr. Brewerton (of Britain) agrees that it is the "intelligent and reasonable patients who have described resisted exercises with the Delorme boot as being extremely boring". It would be unfair to tag as "unintelligent" someone in a different clime or frontier who might persist in progressive maximum-resistance exercises without protest so that, in the words of the weight-lifting advertisements, "he too might have the body-beautiful!"

HAROLD V. CRANFIELD

TREATMENT OF PNEUMONIA

Recent progress in therapy may have changed the outcome of pneumonia but it has hardly altered its incidence at all. The advent of antibiotics has not supplanted the need for general supportive therapy. Some of the following remarks have been inspired by a report to the Council on Drugs of the United States.[1] As in most infectious diseases where toxicity plays a leading role, the patient with pneumonia should receive liberal amounts of fluids, usually of the order of 2500 to 3000 c.c. per day. Increasing the amounts much beyond these points may defeat the purpose by causing too rapid excretion of specific antibacterial drugs. An otherwise healthy patient may withstand moderate degrees of fever without untoward effects; unless there exist specific indications to give antipyretic drugs, fever may be left to itself. It is even said that the antibacterial action of several antibiotics is increased at temperatures above the normal body temperature. If the spikes of fever become alarming, alcohol sponges are the most effective means of dealing with them. The application of local heat or cold or of a tight binder in the event of pleuritic pain seems to be displacing the custom of strapping the chest with adhesive bandages. The possibility of circulatory collapse or shock resulting directly from toxæmia is sometimes overlooked. When present it should be dealt with like any other form of shock. A useful precaution to remember is that, in the use of pressor amines such as Levophed, veins in the lower extremities should be avoided whenever possible on account of the danger of tissue necrosis should any of the drug infiltrate outside the vein. This precaution is particularly applicable in cases of elderly patients.

It is interesting to note that in a recent study in England[2] it was found that aerosol solutions containing detergents did not seem to affect the viscosity of sputum any more than plain water administered in the same fashion. The viscosity of the sputum is often one of the characteristics of staphylococcal pneumonia. This versatile microorganism still eludes the efforts of the bacteriologist to find an antibiotic to which it will remain permanently sensitive. In certain cases enormous doses of penicillin, amounting to 50 million units or more, may be given intravenously in the same way as when dealing with subacute bacterial endocarditis. When administering penicillin in such quantity, one should select judiciously the sodium or potassium salts of this antibiotic with a view to electrolyte balance.

A recent treatment of infections with Klebsiella organisms consists in giving one gram of chloramphenicol every six hours and one gram of streptomycin every eight hours at the onset. A similar regimen can be applied to patients with influenzal pneumonia. If streptomycin is to enter into the therapeutic armamentarium, every effort should be made to rule out the presence of a tuberculous infection which may exist concurrently with any of the other forms of pneumonias. The age, standard of living and occupation of the patient should not be misleading factors in overlooking this possibility, since a survey carried out on university students showed, in one large American centre, that tuberculosis was the most prevalent major disease on the campus from the standpoint of both incidence of infection and clinical lesions.[3]

Important though they may appear, bacterial infections of the lower respiratory tract are eight times less prevalent than atypical and presumably viral infections of the same area.[4] Except for the infections of the psittacosis-ornithosis group, which may respond to the tetracycline group of drugs, the others are not amenable to any specific form of therapy and must be left to follow their course with only symptomatic therapy. The preventive measures with regard to these diseases are still a moot point.

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SALUTE TO DR. FARRAR

We note with pleasure that the April 1957 issue of the *American Journal of Psychiatry* has been taken over by a guest editor, Dr. Paul M. Hoch, and organized as a Festschrift for the regular editor, Dr. Clarence B. Farrar of Toronto. This modest and scholarly man—so long identified with Canadian psychiatry—here receives a well-deserved tribute in the form of original articles and citations.